Confronting the Challenge of Long-term Care in Europe

Denis Kessler*

Introduction

It is an indisputable fact that Europe's population is getting older. This puts pressure on the majority of the social protection schemes in Europe which, founded on systems of distribution, are no longer sustainable in the face of increased needs. The care for those who are no longer autonomous and need external assistance will continue to grow. Insurance can provide realistic, effective, fair and virtuous responses, insofar as the public authorities do not pre-empt the market and a real public-private partnership is established with the merits of a market solution in the European context of the welfare state.

Long-term care is not only the consequence of a choice of lifestyle and social relations, both with family and neighbours, it is also largely a result of genetic determinants as well as day-to-day accidents over which the policyholders have little control. It can therefore be covered by an insurance policy using traditional market methods. Economic analysis and accumulated experience show the market's capacity to meet the objective needs of long-term care. Covering these needs requires that three well-known risks are managed effectively: moral hazard, adverse selection and the escalation of trends.

The concern expressed in various countries, notably in Europe, to satisfy the objectives of the welfare state and to offer all households long-term care cover, even for the most needy, may find a suitable solution within a public-private partnership that is carefully designed to reconcile market incentives and solidarity.

* CEO of SCOR SE.

Nature of long-term care and of the long-term care risk for insurance

Long-term care is a risk that can be objectivised

Firstly, loss of autonomy should be clearly distinguished from illness, disability and handicap, although these four concepts are not totally independent of each other:

- Loss of autonomy denotes an inability to perform some of the most basic everyday activities due to old age (e.g., getting up, dressing, washing, eating, walking and so on) and the need for assistance in order to carry out such activities;
- Illness denotes an objective, temporary situation of ill health (such as fever, depression, etc.) and a need for therapeutic care (i.e. medical consultation, medication, surgical intervention, etc.);
- Disability denotes a reduced capacity for normal activity following an accident or an illness, without necessarily implying the need for assistance;
- Handicap denotes a physical or psychological limitation in the accomplishment of normal activity and may be associated with a need for assistance.

Three main analysis scales are used to provide a way of measuring loss of autonomy that aims to be objective. These are summarised in the Table, which clearly shows their common points and their differences.

We can therefore conclude that there is an apparent consensus on what is actually included in the long-term care that should be covered by insurers. It should be noted that one third of the French insurers use the ADL approach, another third a combination of the ADLs with the AGGIR scale and the last third the AGGIR scale.

The material triggers of long-term care are themselves standard: dementia (25–50 percent of cases), cancer (15–30 percent of cases), cardiovascular diseases (15–30 percent of cases), other neuropsychiatric diseases (10–20 percent of cases), rheumatology (2–10 percent of cases), accidents (5–10 percent of cases) and ophthalmic diseases (1–3 percent of cases).

Table

Main assessment scales used around the world

Katz scale (used throughout the world)		AGGIR scale (used in France)
Activities of daily life (used by American insurers)	Activities of daily life – ADLs (used by most private French insurers, sometimes in connection with AGGIR scale)	Iso resources groups – GIR (used by French public authorities for eligibility to LTC public benefit and by some French insurers) excluding GIR 6
Bathing	Bathing	Occasional help for washing and home care
Dressing	Dressing	Loss of autonomy for more than one ADL
Transferring	Transferring	Help several times a day for ADLs
Feeding	Feeding	Confined or impaired mental faculties
Toileting	–	Bedridden or confined to an armchair + mental faculties severely impaired
Continence	–	–
Loss of autonomy = inability to carry out 2 of these 6 activities without the help of a third person	Loss of autonomy = inability to carry out 2 of these 4 activities without the help of a third person	Loss of autonomy = belonging to one of the last 4 categories above

Source: Katz, Down, Cash and Grotz (1970); SCOR; French Ministry of Social Affairs.

Based on its French portfolio, SCOR's data show that a 60-year-old has a significant probability of suffering a severe loss of autonomy (inability to handle 3 of the 4 ADLs). Women have a 48 percent probability of requiring long-term care before their death, against a mere 30 percent for men. Based on a French survey (FFSA 2005), the remission rate for severe loss of autonomy is negligible (~ 1 percent). For partial loss of autonomy (inability to carry out 2 of the 4 ADLs), the remission rate is much higher (25 percent of the surveyed population with a partial loss of autonomy experienced remission two years after the first survey). Worsening from partial to severe loss of autonomy affects 5 percent of the surveyed population over a two-year period.

Three major risks for the insurer, which determine its insurability

The insurability of a risk depends both on the nature of the risk transferred to the insurer and the insurer's ability to correctly price this risk. Materially, forecasts of the number of persons requiring long-term care are based on four factors: prevalence (the probability of requiring long-term care within the reference population), incidence (the probability of falling into the category of those requiring long-term care), remission (the probability of exiting the category of those requiring long-term care) and mortality (the mortality differential between persons requiring long-term care and those who do not). But to understand the need for assistance related to long-term care, it is also important to consider the existence of potential caregivers, spouses, children or neighbours, who themselves depend on several factors (life expectancy, life expectancy without loss of autonomy, frequency of separation of couples, fertility, rate of employment of children, level of social relations within the family). For the insurer, we can sum up long-term care as carrying three major risks, which determine its insurability:

- The risk of escalation: according to some experts, an extension of lifespan goes hand in hand with an extension of the time spent with a disability, that is, in a situation of total or partial loss of autonomy. Long-term care is an emerging risk whose total cost will increase more rapidly than national wealth. This naturally raises the problem of pricing insofar as the underlying trend is still not properly understood, policyholders themselves being inclined to underestimate the impact involved. The risk, therefore, is that supply and demand curves for long-term care products only meet at a point where the supply of services is very restricted or even inexistent. Studies based on a comparison of several statistical sources nonetheless show that this fear is not grounded and that we are not actually experiencing a "pandemic" of disability, particularly severe disability: there are as many countries where the number of old people requiring long-term care grows more quickly than the number of old people not requiring long term care (cf. Belgium, Japan, Sweden) as there are countries where it grows less quickly (cf. Italy, France, USA; Lafortune and Balestat 2007; Jacobzone 2000). Studies exploring the links between lifestyle and loss of autonomy could also eventually significantly alter the trends observed in the past, once these studies lead to the development of efficient prevention techniques.

- The risk of adverse selection: the only people taking out long-term care policies are people who know that they have a high risk of losing their autonomy. It has been observed that people buying long-term care insurance contracts have a higher probability of losing their autonomy than those who do not buy such contracts (Finkelstein and McGarry 2003), and people who discontinue their contracts have a much lower probability of losing their autonomy than those who do not (Finkelstein, McGarry and Sufi 2005). This is a classic health insurance risk, which should be treated under identical conditions.
- The moral hazard: this probably constitutes the greatest challenge for long-term care insurance. In long-term care, moral hazard has less to do with the behaviour of the policyholder than with his social environment. The perception of long-term care as a risk is a very recent phenomenon. It has less to do with the increasing wealth of society than with rural exodus and the desire for autonomy of both parents and children, with the result that elderly parents are less and less likely to live under the same roof as their children. This development is certainly nearing its end, but it emphasises the point to which the idea of loss of autonomy is determined by social perception. There is no reason to assume that this social perception will stabilise over the next few years. It is even less likely to settle down in that the criteria for loss of autonomy are relatively vague and susceptible to widely varying interpretations depending on the social climate – in the future we may consider that having trouble taking a bath constitutes a sufficient indication of loss of autonomy, etc. The major escalation in handicap allowances, which are still experiencing double-digit growth in developed countries, independently of the actual health status of the populations involved, is a good illustration of what could happen in the future with long-term care. If this risk has not yet materialised for long-term care, it is because the stakes until now have been low. Once long-term care becomes an issue for society and has its own dedicated rights and laws, etc., the risk of ex post escalation of the content of long-term care insurance contracts signed years before, especially through court decisions, may become a reality. This may happen on three levels: the point at which one is considered to have lost autonomy, how severe the loss of autonomy is considered to be, and the level of assistance considered to be normal in relation to a certain degree of loss of autonomy.

The relevance of a market solution and its place in the European welfare state

Market solutions are relevant

In many countries, the private long-term care insurance market is still very narrow, with very different trends: it is experiencing very rapid growth in some countries (e.g., Spain, Italy, South Korea) but is stagnant in others (e.g., Germany, UK, Nordic countries). However, it is a statement of fact that a market exists for long-term care cover, as long as the private offer has not been ousted by an aggressive public offer. What is most worrying for the future is that the long-term sustainability of this aggressive public offer is threatened by the inadequate selectivity with regard to the schemes put in place, as well as by the wider crisis of the welfare state.

The largest worldwide market is the American market, with over 6 million policyholders and 25 years of experience. However, the market contracted at a constant pace of 10 percent per year until only recently. The difficulties that have hit the American market can be explained to a certain extent by the dynamism of the public Medicaid system (Brown, Coe and Finkelstein 2006; Brown and Finkelstein 2004) but also, as we shall see, by the inadequacy of the products supplied by the insurers. The second largest worldwide market, located in Europe, is the French market with around 3 million policyholders, a growth rate of 15 percent per year and 20 years of experience. We should note that in a country like France, where public authorities have only recently committed to covering long-term care, the number of policyholders (~3 million) is significantly higher than the number of people receiving public aid (~1 million). Interestingly, these two leading markets are based on two different models of cover for long-term care risks (Taleyson 2003):

- In the United States, long-term care insurance contracts are generally individual and provide for the reimbursement of care and services costs up to a certain limit, with multiple options. These are products whose philosophy is derived from health insurance products. They are distributed by agents' networks and are tax qualified.
- In France, long-term care insurance contracts can be individual or collective and provide for the payment of a monthly cash benefit, which may be proportionate to the degree of loss of autonomy and adjusted according to the evolution of this loss of autonomy in the latest generation of con-

tracts. These are products whose philosophy is derived from disability annuities products. They are distributed by direct selling networks and are not tax qualified.

Particularly in France, there is a high demand from the public authorities and various associations for the creation of a fifth risk of "social security", as is the case in Germany. Such an approach does, however, present many disadvantages in relation to the advantages that society would experience from a public-private partnership:

- It would come up against the limited leeway for manoeuvring public finances, which would restrain cover in relation to objective needs;
- It would be rigid, without the capacity to adapt to the objective diversity of needs and situations, incapable of experimenting with new forms of risk cover and questioning acquired advantages when they can no longer be justified;
- If based on the "pay-as-you-go" principle, it would transfer the costs entirely to future generations regardless of the principles of sustainable development and would constitute the last in a long series of transfers purely for the profit of the baby boomers;
- It would be very sensitive to being captured by interest groups and would have difficulty in resisting the pressure exerted to distort solidarity depending on matters of economic urgency;
- It would have difficulties preventing cost escalation, with a risk of exploitation by long-term care professionals as illustrated by the agreement on tariffs negotiated between the service providers in certain countries.

It is therefore important to construct a protection system that is suited to the effective needs of people under long-term care, i.e., a system that is:

- In proportion to the degree of effective loss of autonomy;
- Objective, to limit the moral hazard linked to the subjective perception of the loss of autonomy and which, as we have seen above, probably constitutes the major challenge in long-term care insurance;
- Controllable, to manage costs.
- Open to innovation, to best satisfy the needs and reduce the costs;
- Fair and funded, to prevent the costs from being transferred to future generations.

Insurance market cover would avoid these disadvantages or at least would soften them thanks to competition, whilst meeting the effective needs of persons under long-term care.

Co-ordination with the welfare state: which model for Europe?

In Europe in particular, co-ordination with the welfare state is important. The plan would include a universal guarantee for long-term care, which assumes perfect co-ordination between the market and the state, within a public-private partnership of a new kind. This cover could be based on the following main principles:

- Cover of severe long-term care only, which corresponds to a real risk (low frequency, high severity) and a "personal catastrophe" for the households affected (light long-term care is, on the contrary, not a risk but a virtual certainty for each of us);
- Cover which takes the form of an annuity;
- Freedom for households to choose, with tax incentives for protection and eventually penalisation for non-protection;
- Public-private partnership with state intervention for the least solvent demand, in the form of a public benefit, the financing of which would depend on the household's wealth.

Principle 1: A model focussing solely on heavy long-term care with a monetary benefit in the form of an annuity

It is important that the agents have a good understanding of the products and the cover that they provide. The products must be sufficiently simple, without too many options, whilst remaining flexible. They must also be easily comparable from one company to the next, so that the policyholder can optimise his choice. And the insurers must be able to control them so as to limit the risk premium for material uncertainties for the long-term care itself. The system should therefore favour:

- Heavy long-term care, excluding light long-term care, not only because the latter does not pose a real financial problem to households (it does not incur significant expenses and corresponds not so much to a risk as to a virtual certainty) but also because it is more difficult to appreciate objectively, it is more likely to give rise to escalation or even to fraud. Insurance cover would correspond therefore to a consolidated state of long-term care defined with reference to the objective inability to carry out, without the help of a third person, cer-

tain activities of daily life (on the Katz scale). For cases of dementia, cover could be based on Folstein's MMS (mini mental state) examination. The cover would be defined by an approved "long-term care" contract, which would define the level of basic service related to the different degrees of loss of autonomy, in agreement with the profession and the public authorities (possibly including representation of policyholders). The policyholder, duly informed of this approved contract, would not, however, be under any obligation to subscribe to it: he would have the possibility of subscribing to only a part of it, adding additional cover, or even subscribing to a different contract.

- A monetary benefit in the form of a monthly fixed sum. Experience in Germany and the US has shown that "cost-plus" type contracts are largely unsuitable as the policyholder has difficulty in making a choice between the different options faced with a risk of which he tends to have no concrete experience, or of which he refuses to imagine the consequences. In addition, from the point of view of the insurer, recent economic theory (Laffont and Tirole 1993) shows that it is optimal for the principal (the insurer), if he does not want to be the residual claimant, to use fixed-price contracts that attribute a fixed sum to the agent, leaving him to spend it on the necessary care at his own discretion. This contrasts with "cost-plus" type contracts, which reimburse all of the costs exhibited by the agent.

In such a scheme, the revaluation of the benefits provided would be contractual and revisable in accordance with inflation and the change in the rate of the loss of autonomy of the person. It could include a capital payment to equip the home. The degree of loss of autonomy would itself be assessed by an independent appraisal implemented by the profession. Similarly, the contract would be authorised to allow contributions or benefits to be adjusted during the life of the contract in order to make up for any possible escalations which would not be absorbed by the constitution of long-term provisions. Faced with the risk of adverse selection which, as we have seen above, is one of the three major risks which determine the insurability of long-term care, the insurer would be allowed to set an age limit on subscription and to adjust the fee structure depending on the state of health of the insurance applicants. Finally, the contract should allow policyholders to revise their choice and transfer their contract from one insurer to another, with reasonable penalties for the policyholder.

Principle 2: A Model based on freedom of choice with tax incentives and penalisation for non-protection

For such a plan to quickly reach critical mass, it is not only necessary to make households aware of the risk constituted by long-term care at pivotal points in their life (birthday, retirement, change in situation, taking out an insurance contract, etc.) by mobilising the appropriate participants (employers, pension funds, insurers, bankers, etc.) but also to adapt the tax system so as not to reduce interest in this type of guarantee when subscription is not mandatory, given that the agents structurally tend to under-estimate the likelihood of occurrence and severity of far-off catastrophic events (Kahneman and Tversky 1974; 1980).

The policyholder's payments would thus be exempt from social and tax deductions, in the same way as if the payments were made to a social security system.[1] With the aim of fairness, it would also be desirable to go beyond a simple tax exemption and to provide a refundable tax credit which would allow all households, irrespective of their level of income and their marginal tax rate to benefit from the same ratio of tax support. The benefit paid in the event of long-term care would also be exempt from income tax and social contributions, up to a certain limit, given that it is not per se a replacement income. The insurers would only be able to offer long-term care cover which benefits from these advantages if they adhere to a guarantee fund set up and managed by the profession, under the responsibility of the insurers concerned, and which would be authorised to adjust its contribution depending on the financial strength of the insurance company and the quality of its reinsurance programme.

Principle 3: A model supplemented by public welfare, the financing of which would depend on the resources of the households concerned

It is desirable to permit households not to take out insurance or to take out only partial insurance – this choice may be dictated by either financial constraints (insufficient resources) or by an economic and social optimisation calculation.

Any person losing autonomy who is not covered by long-term care insurance or who has only partial cover would be eligible for a public long-term care bene-

[1] Within the framework of collective cover, it would be desirable, for similar reasons, to exempt the company's financial participation in social and tax deductions.

fit. However, only those whose resources are insufficient would be able to benefit free of charge. For the others, a financial participation increasing in line with the household's resources would be required; this could extend as far as a charge on the estate, when households' resources are sufficient, in order to dissuade free-riders.

For this partnership between the market and the state to be effective, it would of course be necessary for the scales on which long-term care is evaluated to be harmonised or at least co-ordinated. Due to its great objectivity, the Katz scale with the autonomous exercise of the ADLs, in association with Folstein's MMS test, would be favoured over others such as the AGGIR scale.

Conclusion

In European countries where there are mandatory health insurance schemes, long-term care should really be "non-medical", in other words, the health care required by the aged needing assistance should be borne by these schemes. In this perspective, long-term care would only provide services to that part of the population experiencing difficulties with daily life. In the US, if the health reform is finally implemented, health care will be borne by this new scheme, allowing insurers to provide long-term care on non-medical basis and thereby reducing the cost of existing long-term care policies.

References

Brown, J. R., N. B. Coe and A. Finkelstein (2006), "Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey", *NBER Working Document* no. 12536.

Brown J. R. and A. Finkelstein (2004), "The Interaction of Public and Private Insurance: Medicaid and the Long Term-Care Insurance Market", *NBER Working Document* no. 10989.

FFSA (Fédération Française des Sociétés d'Assurances; 2005), *Les enseignmements de l'enquête HID*, Paris.

Finkelstein, A. and K. McGarry (2003), "Private Information and its Effect on Market Equilibrium: Evidence from Long-Term Care Insurance", *NBER Working Document* no. 9957.

Finkelstein, A., K. McGarry and A. Sufi (2005), "Dynamic Inefficiencies in Insurance Markets: Evidence form Long-Term Care Insurance", *NBER Working Document* no. 11039.

Jacobzone, S. (2000), "Santé et vieillissement : les perspectives de prise en charge de la dépendence", ISUMA 1(2).

Kahneman, D. and A. Tversky (1974), "Judgement Under Uncertainty: Heuristics and Biases", *Science* 185, 1124–131.

Kahneman, D. and A. Tversky (1980), "Causal Schemas in Judgements Under Uncertainty", in M. Fishbein, *Progress in Social Psychology*, Erlbaum, Hilsdale, New Jersey, 49–72.

Katz, S., T. D. Down, H. R. Cash and R. C. Grotz (1970), "Progress in the Development of the Index of ADL", *The Gerotonologist* 10(1), 20–30.

Laffont J.-J. and J. Tirole (1993), *A Theory of Incentives in Procurement and Regulation*, MIT Press.

Lafortune, G. and G. Balestat (2007), "Trends in Severe Disability among Elderly People", *OECD Working Document on Health* no. 26.

Taleyson, L. (2003), "Private LTC Insurance: International Comparisons", *SCOR Life Technical Newsletter* no. 9.